



45 Earhart Drive, Suite 110, Amherst, NY 14221

HEPATITIS C AUTHORIZATION AND RE-AUTHORIZATION

TEL: (716) 929-1000 | 1-800-809-4763 FAX: (716) 532-7360

Member Name			Today's Date			Date Needed				
Date of birth:		Sex:	Weight:		Prescriber			Hospital/Clinic		
Home Phone Number () ()					Phone Number () ()			Fax Number () ()		
Home Address		City	State	Zip	Address			City	State	Zip
Member's Insurance ID:					Office Phone #:			Office Fax Number:		
Allergies:					Office Contact:					

DRUG SELECTION AND STATEMENT OF MEDICAL NECESSITY

Primary Diagnosis: _____
 ICD10 Code: _____ Genotype: _____
 Estimated Length of Therapy: _____ HCV
 RNA: _____ On Date: _____ ALT: _____
 AST: _____

If ALT is WNL:

- Submit liver biopsy results _____
- Is this patient motivated to complete treatment and have you discussed the risks vs. benefits and adverse effects of therapy with the patient or the patient's guardian?
 Yes No

Fibrosure test score _____

APRI score: _____

Is patient naive to therapy? Yes No

If no, please provide details of previous treatment including medication, dosage, dates of treatment and baseline, and 4 and 12 week HCV RNA lab values for this prior treatment: _____

Please include a list of failed therapy:

Do any of these apply (check all that apply)?

- Female patient who is pregnant
- Male patient whose female partner is pregnant
- Patient has autoimmune hepatitis
- Patient has decompensated liver disease
- Patient has hemoglobinopathies (e.g., thalassemia major, sickle cell anemia)
- Alcohol or drug use in past 6 months
- Patient is co-infected with HIV
- Psychiatric disorder
- Has this patient been compliant with HCV disease evaluation, appointments, procedures, and medication regimen
 Yes No

Additional information requested:

Drug Name	Dose and Frequency
<input type="checkbox"/> Daklinza	_____
<input type="checkbox"/> Epclusa	_____
<input type="checkbox"/> Harvoni	_____
<input type="checkbox"/> Mavyret	_____
<input type="checkbox"/> Olysio	_____

Please check all that apply if yes:

- Co-infected with Hepatitis B
- Sulfa allergy
- History of liver transplant
- Decompensated liver disease
- Severe hepatic impairment (Child Pugh Class C)

Ribavirin

Please check all that apply if yes:

- History of thyroid disorders
- Has Diabetes Mellitus
- History of Cardiovascular disease
- CrCl < 50 ml/min

Confirmed patient will use at least 2 effective methods of contraception during treatment, and monthly pregnancy tests during, and 6 months after treatment Yes No

Sovaldi

Please check all that apply if yes:

- Patient life expectancy > 12 months
- Have baseline neutrophil count
- List SCr: _____ and weight(lbs) _____

Patient verbally or in writing commits to documented planned course of treatment (anticipated blood tests and visits) Yes No

Technivie

List GFR _____

Viekira / Viekira XR

Please submit documentation of the following:

- Patient is without decompensated cirrhosis
- Patient does not have hepatocellular carcinoma

Vosevi

Zepatier

Other